Boldt (H. J.)

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THE TREATMENT OF POSTERIOR DISPLACEMENTS OF THE UTERUS.

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The treatment of posterior displacements of the uterus has received so much attention from the hands of writers, that it is almost necessary to offer an apology if one intends to say something more on this subject, especially when there is nothing new to be offered. My excuse, however, is one which I hope will make the transgression on the space of a medical journal pardonable—namely, to attempt to prevent the family physician to become imbued with the idea that a posterior displacement so frequently requires an operation as one would be led to believe from the writings of some authors, and also to prevent the belief to become general that vaginal fixation is the operation for this condition, and that operation should consist of the vaginal fixation of the uterus.

I am led to write a few remarks on the subject by a well written article by Dr. Wakefield, in the *New York Medical Record* for June 19th. I regret very much that the doctor did not give the references for the following statement: "We are told by nearly all writers that before taking into consideration any operative procedure for the cure of this affection, we should, if possible, place the organ in its normal position by bimanual manipulation and retain it there for several months by means of pessaries or tampons, until the round ligaments and other supports have had a chance to regain their natural tonicity. We are then told that should this fail we are justified in considering some operative treatment for the patient's relief, providing the symptoms are sufficiently troublesome to warrant us in subjecting her to an operation." He says that he cannot agree with such advice. Neither can I, nor any one else who understands anything about gynecology. Neither am I acquainted with any exponent of this department who would make this statement with the advancement which gynecology has attained during the past few years. A patient who has an uncomplicated posterior displacement, if the uterus can be retained in anteposition by means of a *properly* adjusted pessary will give no symptoms due to the former posterior displacement, and consequently an operation is never indicated, except when the patient's mind is in such condition that the mere fact of her knowing that she wears a uterine supporter has a deleterious influence on her. The pessary itself, if it be one properly selected, causes no inconvenience whatever; the patient, in fact, should not be aware of her wearing one, except by the knowledge that she feels better. The simple posterior displacements of congenital origin, if at all productive of symptoms, will hardly ever be benefitted by the use of a pessary, because the body of the uterus will usually flex over the upper bar; this is also the case in many posterior displacements of multipara. I do not wish to discuss the anatomical reasons for this, but simply limit myself to clinical facts. In such cases there is no operation in gynecology which is crowned with more satisfactory, nay, with such good results, as shortening the round ligaments, if performed *correctly*, and this I say not from belief, from hearsay, or from having seen some of my colleagues do the operation, but from practical experience in a large number of cases upon whom I performed the operation and in which I could follow the results for a long period, in none less than one year. From the above it is obvious, that not the operation or the respective form of

treatment plays the important role in the first instance, but the indication for any one variety of treatment stands foremost. I have not heretofore written a word in favor of shortening the round ligaments, although I began doing the operation ten years ago, but I feel myself called upon to defend it now, since my experience is sufficiently large and dates back long enough. It appears to me that those who have so many objections to it seemingly have had insufficient personal experience with it. I have yet to find an operator, who having performed it fifty or more times, utter a word of adverse criticism against it. I admit that some of the objections enumerated by the opposing writers are correct; the ligaments at times are difficult to find, yet in no instance have I failed to find them. They are not infrequently thin at the terminal ends, but the increase in size as we approach the uterine cornu is sufficient in all cases to keep the uterus permanently anteposed if the shortening is made to that extent. Sometimes a ligament when thin and adherent in the inguinal canal will tear when making traction upon it, but this so seldom occurs that we should not take such occasional accident into account; in my experience it has happened either four or five times, and in all cases except one instance I have been able to again find the ligament and shorten it as desired, and in this one case the result with shortening only the one ligament was all that could be desired, as far as the position of the uterus and the complete relief of all symptoms were concerned. When suppuration occurs it is invariably the fault of some error in the technique or the material used. Wounding of the femoral artery, as mentioned by Dr. Wakefield, can not occur; "unskilled" hands have no business to do this or any other operation, and the assistant mentioned by the doctor, as having been cited by Dr. Mundé, who was about to tie off the artery mistaking it for the ligament, should not have been entrusted with work which requires a full knowledge of the anatomy of parts upon which an operation is contemplated. The only objection to which I concede as being valid, is that occasionally a hernia may result in those cases who have had the misfortune, owing to some oversight or error, to have more or less suppuration in the wound. It is said by some of the adversaries to this operation that it is successful in only part of the cases. This assertion I most emphatically oppose. I have stated above, that the secret of treatment of any kind is to know the proper indication for applying the respective therapeutic agent. If the operator expects to get a good result from this operation in a case of adherent retro-displacement, although the adhesions be slight, unless they be first thoroughly and completely separated, he will be disappointed; the same holds good if small fibromata are present in the uterus, if they are not enucleated, or if procidentia, even if only of the first degree, is present. In short it is applicable only in cases of uncomplicated posterior displacement, and in such the anatomical result is excellent in every instance, however, with the proviso *that the operator knows his business.*

Ventral fixation or hysterorrhaphy have been brought in comparison with the Adam-Alexander operation by various writers. There is no comparison between the two; anyone who will perform hysterorraphy on the indication which I have given for shortening the round ligaments, is in my opinion guilty of exercising very poor judgment, to say the least. I have been guilty of such error in former years before having had experience with a better operation, and I openly confess my mistake. At the present time no one has the right to open the abdomen for the sole purpose of ventro—fixating a freely mobile uterus. It is only indicated when the uterus is fixed by such dense adhesions that these cannot be severed by forcible rapid massage according to B. S. Schultze, or the ordinary pelvic massage according to Thure Brandt, as

described by me in the *American Journal of Obstetrics* in 1889. Even in a number of instances with such dense adhesions, I have lately opened the posterior cul-de-sac and severed the adhesion from below with my fingers and scissors, and then finding that the adnexa were not diseased too much, so that self-repair could take place, I shortened the ligaments with most gratifying ultimate results. The incision behind the uterus must be made sufficiently large to allow the operator to work freely with his fingers, and after all adhesions have been completely torn or cut, after which it can again be closed, only leaving sufficient opening for a drain, which is left in the peritoneal cavity for twenty-four hours, to give exit for the sanguinous oozing from the torn and cut adhesions. I also consider ventral fixation indicated in a limited number of patients having procidentia with or without backward displacement. It is self understood that if the cervix or the perineum requires repair, that this should also be done at the same time. It may be permissible for me to say here that I am astonished to sometimes see the citation of a very large number of operations, in a comparatively short space of time, for the relief of simple posterior displacement, by a single operator. It is obvious to me that such operator is either not possessed with good judgment, or that he is not conscientious, or perhaps afflicted with "operating fever," because as I have already stated, only a moderate percentum require operation at all, and considering that I personally see not less than 300 to 350 such cases annually in a clientele of more than 3,500 new patients in my clinics and private practice, and comparing this number with those upon whom I find an actual necessity for operation, I believe that I am justified in making the above assertion.

A word now as to vaginal fixation, that operation for which a number of writers have spoken so favorably, including myself at a former time. Seven years ago I began to do the operation from which the latter modifications arose, namely the utero-vaginal ligaturing according to Schuecking. In 1891 I read a short paper on the subject before the New York State Medical Society. In 1892 I did a modified operation, and was the first also to do the vaginal fixation as practiced by Duehrssen. This was some time before the operator mentioned published his procedure. My knowledge was due to the kindness of one of the internes at the Charité hospital in Berlin, who wrote me a very graphic description of the work. All vaginal methods have, however, been given up by me, because the facts were made too convincing that the ultimate outcome is bad. Vaginal fixation is a dangerous operation for women who are liable to become pregnant again; I will not cite details, the literature is teeming with the citation of examples. The only vaginal operation which I can concede to for the cure of uncomplicated retroflexion or version, is the shortening of the round ligaments by this route; but why should we constantly seek something new when the old and well tried method has given such satisfactory results *to all who have mastered it?*

If, however, one has pelvic work to do per vaginam in which it is necessary to open the peritoneal cavity, as the removal of an ovarian cyst, or an exploratory vaginal section, and he finds it necessary to correct a displaced uterus, let the attachment be made to the bladder peritoneum and not to the vagina, which is much safer in its result for the patient should she subsequently become pregnant.

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